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A survey of PTSD screening and referral practices in VA addiction treatment programs☆

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Abstract

Veterans with posttraumatic stress disorder (PTSD) and substance use disorders (SUDs) demonstrate worse outcomes following treatment for SUDs than do veterans with SUDs only, and so PTSD treatment may enhance SUD outcomes for patients. A survey of current practice patterns in VA SUD treatment programs was undertaken to determine their concurrence with emerging practice guidelines for the assessment and treatment of SUD–PTSD comorbidity. Clinicians in outpatient SUD clinics and/or inpatient SUD programs were surveyed in six VA medical centers in 1999 and 2001 (respondents $n = 57$ and $n = 39$, respectively). Although one half to two thirds of clinicians working with SUD patients routinely screen for trauma exposure and PTSD, few assessments are systematically conducted using validated measures. Routine referrals to PTSD specialty and dual-diagnosis programs and to veterans' centers are made by between 35% and 60% of providers across inpatient and outpatient settings. Implications for improvement of clinical outcomes are discussed.

Keywords: Substance use; Posttraumatic stress disorder; PTSD; Trauma; Veterans

1. Introduction

Syntheses of the empirical literature on posttraumatic stress disorder (PTSD) and substance use disorders (SUDs) have documented the frequent comorbidity of these conditions in clinical and community samples and have given rise to clinical practice guidelines that address the connection between these co-occurring conditions. The Department of Veterans Affairs (VA) is exploring integrated treatment for PTSD and SUDs, notably, in its establishment of several dual-diagnosis intervention programs and promulgation of a clinical practice guideline for managing SUDs (Department of Veterans Affairs/Department of Defense, 2001). This guideline recommends that, with respect to assessment and diagnosis, the patient's relevant history and life context be considered as the basis for an integrated summary and treatment plan; for patients managed in specialty care, the guideline recommends that comorbid psychiatric conditions and developmental, as well as military, history be assessed.

Data on the extent to which awareness of the link between the two disorders has penetrated traditional SUD treatment services in VA can inform specific strategies to increase use of best practices in caring for veterans dually diagnosed with SUD and PTSD. To that end, the current study—a survey of VA clinicians in specialized SUD treatment programs—was undertaken to determine practice patterns with respect to screening, treatment, and referral for PTSD.

1.1. Background: Why assess for PTSD in SUD treatment?

PTSD and early trauma exposure are common among veterans with SUDs. Although screening studies in VA SUD

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treatment programs have reported rates of current PTSD as high as 35–46% (Hyer, Leach, Boudewyns, & Davis, 1991; Triffleman, Marmar, Delucchi, & Ronfeldt, 1995), analysis of administrative data indicate that only 21% of VA SUD patients receive a PTSD diagnosis (Rosen, Ouimette, & Moos, 2001, unpublished manuscript). Further, even if providers do assess for combat-related PTSD, they may not assess for childhood abuse or sexual assault, which are also common among veterans with SUDs (Ouimette, Moos, & Brown, 2003; Schaefer, Sobieraj, & Hollyfield, 1988; Triffleman et al., 1995).

Research suggests that male VA SUD patients with PTSD (e.g., Schaefer et al., 1988; Hyer et al., 1991; Sharkansky, Brief, Peirce, Meehan, & Mannix, 1999) or with histories of childhood trauma (e.g., Krinsley, Brief, Weathers, & Steinberg, 1994) experience higher levels of problems than do SUD patients without PTSD or childhood trauma. Dually diagnosed veterans present with a longer history of substance use, more symptoms of substance dependence, and more treatment episodes. Problems in living—legal difficulties, social conflicts, violent behavior, and suicide attempts—are exacerbated relative to individuals without PTSD. A study examining the characteristics of SUD–PTSD comorbidity in non-help-seeking female Vietnam-era veterans indicated that dually diagnosed women were more likely to report a history of childhood sexual abuse, a greater number of childhood traumas, more sexual assaults as adults, and greater sex-based wartime stress (i.e., sexual harassment) than did women with PTSD only and women with neither diagnosis (Ouimette, Wolfe, & Chrestman, 1996).

Emerging evidence from a series of reports following the course of treatment for male veterans in VA SUD programs suggests that veterans with concurrent PTSD and SUD improve less during treatment than do veterans with either SUD alone or other, comorbid psychiatric conditions, along several change dimensions: self-reported psychological distress, the use of coping skills, and the ability to harness adaptive cognitions (Ouimette, Ahrens, Moos, & Finney, 1997, 1998; Ouimette, Moos, & Finney, 2000). The results of one investigation showed that, 1 year following SUD treatment termination, patients with PTSD were significantly worse than patients with an SUD only or an SUD and a psychiatric condition other than PTSD on measures of problems from substance use, distress, and social support (Ouimette et al., 1997). Among both male and female veterans, a self-reported history of physical or sexual abuse is also associated with poorer SUD treatment outcomes (Rosen, Ouimette, Sheikh, Gregg, & Moos, 2002).

Overall, these findings suggest that comorbid PTSD may limit the effectiveness of conventional SUD treatment. The self-medication model of addiction maintains that substance use is driven by an attempt to seek relief from underlying psychiatric symptoms (Khantzian, 1985, 1997). For example, individuals with PTSD can be highly susceptible to abusive drinking and the use of opiates because of the reduction in hypervigilance toward trauma-related cues that these drugs afford (Kosten & Krystal, 1988). Moreover, given the data on alcohol-induced reductions in cognitive biases for threatening information in individuals with anxiety sensitivity (Stewart, Peterson & Pihl, 1995), alcohol might similarly reduce the cognitive biases for trauma-relevant information in patients with PTSD, thereby controlling the cognitive re-experiencing of PTSD symptoms (McNally, 1995). Substance use, then, contributes to the cycle of emotional and cognitive avoidance characterizing PTSD and, because withdrawal may exacerbate PTSD symptoms (Redmond, & Krystal, 1984) even after detoxification, it is not surprising that comorbid PTSD can impede the effectiveness of directed interventions for SUDs.

The literature also bears out that outpatient PTSD service use is a major predictor of SUD outcomes. SUD–PTSD patients who receive enduring PTSD treatment following discharge from inpatient addiction programs are more likely to achieve stable remission of substance use problems than those patients who do not receive such intervention (Ouimette et al., 2000), further suggesting the utility of greater detection and referral. From a number of perspectives then, addressing PTSD issues appears critical in improving outcome for treatment of comorbid SUDs.

1.2. Study rationale

The empirical literature argues for the utility of assessing trauma exposure and PTSD symptoms in SUD treatment. Some observational data indicate that dually diagnosed patients fare better when treated for comorbidity (Ouimette et al., 2000). Such positive effects cannot be achieved, however, unless SUD patients are screened for PTSD and trauma and, for those screening positive, referred to PTSD treatment. The current investigation was undertaken to address the following questions: When treating patients with SUD, how commonly do VA providers assess for PTSD and trauma exposure? How often do VA SUD treatment providers refer patients with PTSD to PTSD specialty treatment?

2. Methods

The results reported here are drawn from an evaluation of PTSD practice patterns in six VA medical centers in the western United States. Two surveys were conducted: first, between July and December 1999 and second, between January and June 2001.

2.1. Sample

The methods and findings for the overall sample of mental health treatment providers have been reported previously (Rosen, 2001; Rosen et al., 2004). The present investigation focused more closely on providers dispensing SUD treatment (i.e., all clinicians who worked in an

Table 1
Participant characteristics

	Providers working in addiction treatment (total sample)		Providers working in outpatient settings		Providers working in inpatient settings		Providers working in both settings	
Date of survey	1999	2001	1999	2001	1999	2001	1999	2001
Total respondents (*n*)	57	39						
Staff nurses	26% (15)	33% (13)	5	3	10	9	0	1
Psychologists	23% (13)	21% (8)	10	8	2	0	1	0
Substance abuse counselors/ rehabilitation technicians	14% (8)	15% (6)	5	5	2	1	1	0
Social workers	12% (7)	10% (4)	5	4	1	0	1	0
Psychiatrists	12% (7)	8% (3)	5	2	0	1	2	0
Other	13% (7)	13% (5)	4	2	3	3	0	0

outpatient SUD clinic and/or an inpatient SUD program; we speculated that providers in residential SUD programs, which focus on acute patient stabilization, might be less oriented to comorbid presenting problems).

Questionnaires were distributed by mail, followed by up to five rounds of mail and telephone contact to optimize participation. Overall response rates were 85% and 70% for the first and second surveys, respectively. Sample characteristics, reflecting surveillance across professions, are summarized in Table 1.

2.2. Measures

Survey questionnaires inquired about specific assessment, intervention, and referral practices for comorbid SUD–PTSD. Questions about PTSD management assessed compliance with expert consensus guideline recommendations for its treatment (Foa, Davidson, & Frances, 1999; Foa, Keane, & Friedman, 2000). Clinicians were asked how often they questioned their patients about a history of combat and other trauma, screened for PTSD symptoms, and used validated self-report and interview measures of trauma exposure and PTSD. Questions were of the form: "For how many of your patients do you (perform specific practice addressing these problems)?" Responses were given on a 6-point scale, ranging from 1 (*less than 10% of my patients*) to 6 (*over 90% of my patients*). Participants also were allowed to report "Someone else does this," given that certain procedures (PTSD assessment) might be delegated to other staff members. Providers in SUD treatment programs were asked about their use of psychotherapy addressing PTSD symptomatology, as well as frequency of referral to other programs, including VA PTSD specialty programs, SUD–PTSD treatment programs, dual diagnosis programs not specializing in PTSD treatment, and veterans' centers (community-based PTSD programs using a peer counseling model).

2.3. Data analysis

For estimates of frequency of practice, an intervention was defined as being used "routinely" if respondents reported its provision for at least 70% of patients (we assumed that a given procedure might be inappropriate for some patients). "Someone else does this" responses were analyzed in two ways to arrive at best- and worst-case estimates of frequency of practice: Best-case estimates of practice assumed providers were accurate in reporting that someone else was responsible for the procedure (i.e., "Someone else does this" responses were treated as nonapplicable data). Worst-case estimates treated "someone else does this" responses as equivalent to "I do this for less than 10% of my patients," on the assumption that there actually might not be any other staff member providing that service. A wide range between best- and worst-case estimates for a given intervention indicates that a large proportion of providers reported, "Someone else does this."

For all statistical analyses, data were treated as continuous to maximize power, given the small sample sizes. Changes in screening and referral practices over time were analyzed using paired t tests. Only results that were significant in both best- and worst-case estimates of care are reported.

Differences in screening practice between providers in outpatient and inpatient addiction treatment settings were analyzed using independent t tests. Differences in screening practice by profession were analyzed via ANOVA. Independent t tests and ANOVAs were performed four times using best- and worst-case estimates for each of the two survey iterations. Reported results are those that were significant in at least three of the four analyses; this approach avoided emphasis on results that might be significant in a single survey year only or those that might apply to either best- or worst-case estimates.

3. Results

Fig. 1 summarizes the PTSD assessment practices of participants working in SUD treatment settings. The bars delineate the range between worst- and best-case estimates of the proportion of clinicians who endorsed routine use of various assessment procedures. For purposes of comparison, we also included items on screening for depression, another psychiatric disorder often comorbid with SUDs.

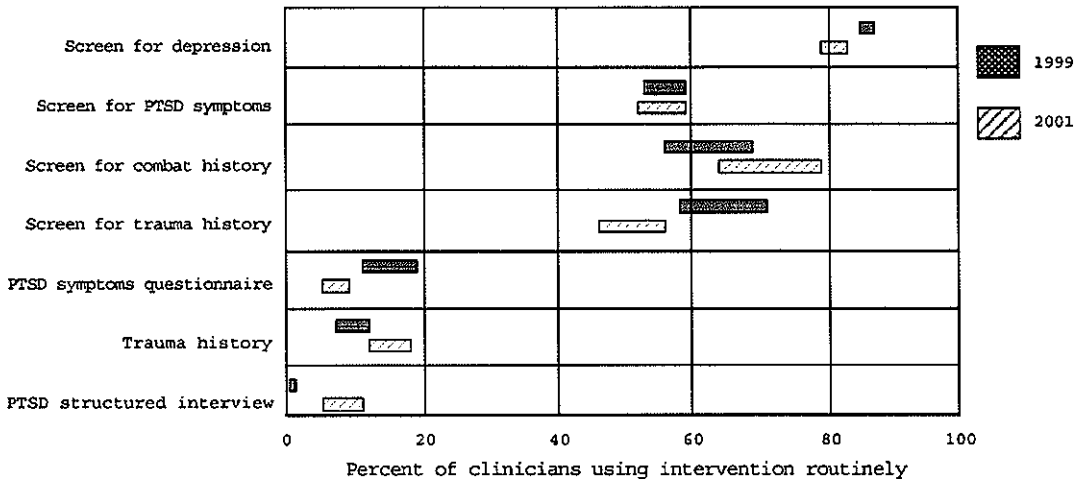

Fig. 1. Routine PTSD assessment practices among providers working in addiction treatment settings.

3.1. Assessment of SUD–PTSD comorbidity

Roughly half of all providers in addiction treatment settings routinely screened for PTSD symptoms. Approximately one half to three quarters of providers routinely inquired about combat exposure and more than one half to two thirds of providers screened for other lifetime traumatic events. Interestingly, providers in VA SUD treatment settings inquired about PTSD symptoms or trauma exposure less often than they assessed for depression. Fewer than 20% of clinicians in these settings routinely used validated questionnaires to assess trauma exposure or PTSD symptoms. Almost none of the clinicians routinely conducted structured diagnostic interviews, such as the Clinician-Administered PTSD Scale for DSM-IV (Blake et al., 1995) or the PTSD section of the Structured Clinical Interview for DSM-IV Axis I Disorders (First, Spitzer, Gibbon, & Williams, 1995).

Overall, assessment practices among all providers in addiction treatment and between providers in inpatient versus outpatient programs were relatively stable over time, with no significant changes noted from Year 1 to Year 2. There were also no significant differences in assessment practice between outpatient and inpatient settings.

Although profession of provider did not significantly impact frequency of practice in any domain, psychiatrists were the professionals most likely to routinely screen for PTSD (perhaps trusting clinical judgment over conduct of structured interviews); the difference noted between psychiatrists and other professionals, however, was not statistically significant. Psychologists and nurses were the only professionals to administer self-report measures of PTSD symptoms; psychologists, nurses, and SUD counselors/rehabilitation technicians were the only professionals to administer self-report measures of trauma history.

3.2. Treatment and referral practices

Fig. 2 summarizes PTSD treatment and referral practices among providers in SUD treatment settings. Patients with detected PTSD or trauma history were most frequently referred to PTSD specialty programs at VA medical centers (routine practice by roughly one third to one half of

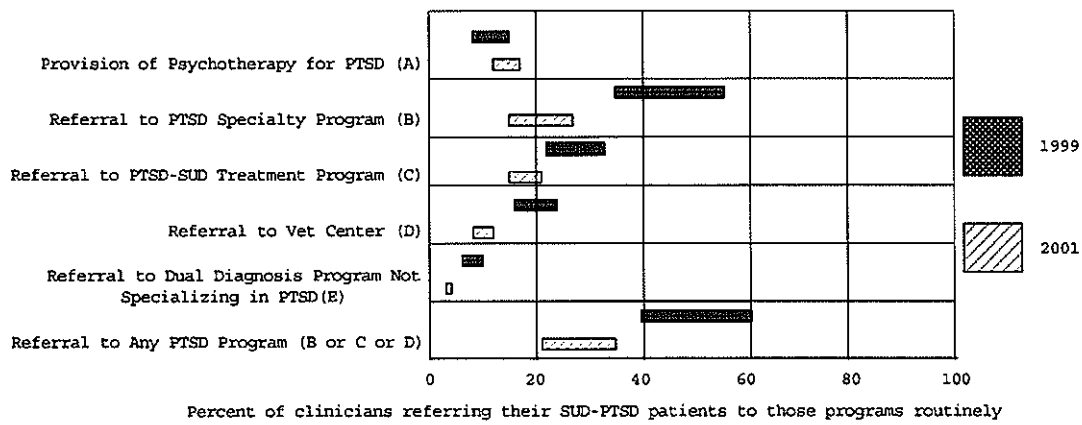

Fig. 2. Routine PTSD treatment and referral practices among providers working in addiction treatment settings.

providers). Approximately one third of providers referred to a specialty dual-diagnosis SUD–PTSD program (only one such program was available in the region). Patients were less often referred to veterans' centers (counseling centers specializing in PTSD that are independent of VA medical centers) and to dual-diagnosis programs not specializing in provision of care for PTSD. Fewer than 20% of clinicians themselves routinely administered PTSD-focused psychotherapy for their SUD–PTSD patients. Referral patterns did not differ significantly across years or by (inpatient vs. outpatient) treatment setting.

Between 40% and 60% of SUD providers routinely (i.e., for over 70% of patients) referred their PTSD patients to any one of the three major referral programs (PTSD specialty programs, dual-diagnosis PTSD/substance abuse programs, or veterans' centers) in Year 1, with a nonsignificant, but notable decrease in referrals noted for Year 2 (with between 20% and 35% of clinicians routinely referring their patients to any one of these programs). The pattern of referrals did not differ significantly between inpatient and outpatient settings. Overall, for between 40% and 60% of providers in addiction treatment settings in 1999 (and for between 65% and 80% of providers in 2000), patients with PTSD were not routinely referred for specialty treatment.

To advance our understanding of referral patterns, we assessed not only how many providers referred to any one of the three major referral programs (PTSD specialty programs, dual-diagnosis PTSD/substance abuse programs, or veterans' centers) routinely (i.e., for over 70% of patients), but also how many referred out to any two of the three programs occasionally (for between 30% and 70% of patients). Frequency of routine referrals decreased markedly between the two surveys. Of the clinicians in addiction treatment responding to the survey in 1999, 49% (worst case) to 78% (best case) of providers reported at least occasional referrals to PTSD programs, compared with 36% (worst case) to 61% (best case) of providers in 2001.

4. Discussion

In the current study, providers of SUD treatment in VA appeared to assess fairly routinely, although not systematically, for combat and other trauma history and for symptoms of PTSD. Between one half and two thirds of providers endorsed customary verbal screening practices in these domains. However, validated assessment instruments, as recommended in practice guidelines (Keane, Weathers, & Foa, 2000), were rarely employed. We found little difference in screening practices over time, by profession, or between outpatient and inpatient settings.

Providers who work in VA SUD treatment settings perform almost as well vis-à-vis verbal screening for PTSD as do other mental health providers in VA, and about 12–17 percentage points lower in this domain compared to PTSD specialists (Rosen et al., 2004). Clinicians in SUD treatment programs do somewhat better than other mental health providers but not as well as PTSD specialists in other screening domains: about one quarter to one half of specialists routinely employ validated measures to assess PTSD symptoms or trauma exposure (Rosen et al., 2004), compared with less than 20% of providers in SUD treatment settings (between 5% and 15% of mental health generalists systematically conduct PTSD or trauma assessment; Rosen et al., 2004).

In examining the treatment and referral practices of providers in SUD treatment settings, we emphasized provision of PTSD-focused psychotherapy and routine referral of patients to three major referral sites: PTSD specialty programs, dual-diagnosis PTSD/substance abuse programs, or veterans' centers. Our findings showing a decrease in referrals over time are consistent with VA administrative data for that period (Fontana, Rosenheck, Spencer, & Gray, 2001, 2002). This trend may be because of little reinforcement for referral of SUD–PTSD patients or to a paucity of PTSD referral resources. Providers also may feel that PTSD can only be addressed after achieving stable remission for an SUD (dually diagnosed patients encountered across work settings have been regarded as more challenging to treat than individuals with either disorder alonel Najavits, 2002).

We were unable to ascertain whether veterans followed through with referrals for PTSD treatment, and although referrals to PTSD specialty programs and veterans' centers appear to have declined since 1999, it is not known why this might be so. It would be important to determine not only how many patients are routinely screened out of PTSD specialty programs due to an active SUD, but also their further disposition with respect to management of PTSD symptoms if they are unwilling to participate in SUD treatment.

Many VA providers may be unaware of the prevalence of noncombat trauma. Other knowledge and skills deficits—familiarity with the ways in which PTSD impacts maintenance of, and recovery from, SUDs, and competence in administering and interpreting PTSD screening measures—may compromise assessment and referral. It may be that the press to screen for PTSD is low if a site lacks the resources to handle the likely augmentation in patient load. Furthermore, administrative guidelines influence practice conduct, and current VA standards call for the assessment and documentation of POW status and history of military sexual trauma, but not for screening for PTSD. VA-mandated standard of practice may change, however, as Department of Veterans Affairs/Department of Defense guidelines for PTSD are currently being developed (Kudler, 2003).

SUD providers may ascribe to the belief that psychiatric issues are secondary relative to those of substance use (Ouimette, Brown, & Najavits, 1998; Ouimette et al., 2003) and may be concerned that patients may use a psychiatric diagnosis to "excuse" their substance use. Provider discomfort in inquiring about trauma/PTSD might also be a factor (Ouimette et al., 1998). Patient attitudes, too, may

drive clinicians' reluctance to inquire about trauma history for fear of triggering negative reactions. In a study that inquired patient beliefs about how PTSD and trauma affect treatment course, about 40% of individuals maintained that talking about trauma would worsen their condition. Patients overwhelmingly identified emotional pain, shame, and self-blame as barriers to sharing trauma history (Brown, Stout, & Gannon-Rowley, 1998). Among patients who were referred to PTSD treatment, however, almost 75% complied with the referral, suggesting that patients' concerns can be neutralized by therapists' recommendations.

4.1. Recommendations

Between one half and two thirds of clinicians in VA addiction treatment programs screen for PTSD symptoms and lifetime trauma exposure as routine practice, but our results indicate that PTSD may be underdiagnosed in these settings, given the comorbidity prevalence figures. Although this study requires replication in a wider, more heterogeneous sample before clinical or policy recommendations can be emplaced, we believe that comorbidity capture might be improved if PTSD symptom and trauma history screening were provided for all patients presenting for SUD treatment in VA, using validated assessment measures in concordance with practice guidelines (Foa et al., 1999, 2000).

Routinized screening for PTSD and trauma exposure, however, might not be sufficient to alter treatment decisions (Spitzer, Kroenke, & Williams, 1999). A disconnect can occur when different staff members are responsible for intake assessment and treatment planning. Parallel interventions, therefore, might be needed to (1) increase PTSD screening by assessment staff and (2) promote appropriate diagnoses and referrals by clinical decision makers based on screening information.

Accordingly, VA sites might explore outreach (perhaps via workshops and mail or telephone follow-up) and the use of auditing/feedback trails to capture PTSD diagnoses and promote referrals in VA SUD treatment programs. PTSD specialists might administer workshops on dual diagnosis of SUD and PTSD to assessment staff in SUD treatment programs and to clinical decision makers, with dissemination of, and training on, validated self-report and interview measures of trauma and PTSD. Auditing might be implemented to monitor referral visits. These activities could impact several causally linked outcomes: rates of PTSD screening, proportion of new SUD patients diagnosed with PTSD, proportion of patients who screen positive for PTSD and are then referred for (and complete) a visit for PTSD treatment, resource use, and SUD–PTSD treatment efficacy. Outcome measures could be tailored for use with dually diagnosed patients—an increase in the ability to tolerate urges to use, rather than a decrease in their frequency, for example, might be a more appropriate outcome in this population.

Future research might be directed toward testing the effectiveness of enhanced PTSD screening, diagnosis, referral, and follow-up in VA substance abuse treatment programs relative to treatment as usual. Other investigations might be directed toward elucidation of likely barriers to these activities (i.e., staff attitudes and motivation, as well as patient beliefs).

4.2. Summary

Although this investigation highlights several important shortfalls in detection and provision of treatment for veterans dually diagnosed with PTSD and SUDs, the study is limited in several respects. Data derived from clinician self-reports may not mirror actual practice. Variability in responses across interventions, however, and the consistency of aggregated responses over time suggest that respondents could differentiate procedures they used more frequently from those they used less often. The participant sample was culled from the western part of the Unites States, where several academically affiliated VA medical centers with strong expertise in PTSD are located. Results may not be representative of VA care nationwide, given possible geographic variation in practices (Ashton et al., 1999). The investigators did not survey providers from VA-affiliated Vet Center counseling programs, which are key providers of veteran PTSD care, that operate independently of VA medical centers. Finally, as mentioned earlier in this discussion, results cannot speak of either the quality of care delivery or patient follow-through with recommendations for referral.

In sum, these two surveys of SUD–PTSD treatment practices in VA suggest that clinicians working in SUD treatment programs perform almost as well as other mental health providers in screening for trauma and PTSD, which are assessed regularly, if not systematically. Further study is recommended to explore obstacles to implementing best practices outlined in emerging guidelines for treating SUD–PTSD comorbidity, including clinician knowledge and attitudes and resource availability.

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